EXHIBIT 1

STATE OF SOUTH CAROLINA	)	IN THE COMMON PLEAS COURT
	)	SIXTH JUDICIAL CIRCIT
COUNTY OF FAIRFIELD	)	
	)	
	)	C/A No: 2022-CP-20-
Barry Belton and Dorothy Belton, individually, and as Personal Representatives of the Estate of Kevon Belton,	)	SUMMONS
Plaintiffs,	)	
vs.	)	
Humana Insurance Company,	)	
Defendant.	)	

TO THE DEFENDANT ABOVE-NAMED:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this matter, a copy of which is herewith served upon you, and to serve a copy of your Answer to Said Complaint upon the Subscriber at her office, 1031 Center Street, West Columbia, South Carolina within thirty (30) days after service hereof, exclusive of the day of such service; and if you fail to answer the Complaint within the time aforesaid, then the Plaintiff will apply to the Court for default judgment for the relief demanded in the Complaint.

BILLY R. OSWALD LAW FIRM, LLC

BY /s/ Bryn B. Osborne
S.C. Bar No.: 104353
1031 Center Street
West Columbia, South Carolina 29169
(p)(803) 796-7260;(f)(803) 796-1055
bryn@oswaldlegal.net
ATTORNEYS FOR PLAINTIFF

January 27, 2022

STATE OF SOUTH CAROLINA COUNTY OF FAIRFIELD Barry Belton and Dorothy Belton, individually, and as Personal Representatives of the Estate of Kevon Belton, Plaintiffs, vs. Humana Insurance Company, Defendant.	IN THE COMMON PLEAS COURT SIXTH JUDICIAL CIRCIT C/A No: 2022-CP-20- COMPLAINT Breach of Contract Bad Faith Refusal to Pay Insurance Claim (Jury Trial Demanded)

The Plaintiffs above named, complaining of the Defendant above named, alleges and says as follows:

1. Plaintiffs Dorothy Belton and Barry Belton are residents of Fairfield County, South Carolina and are the duly appointed personal representatives of the Estate of Kevon Belton.

2. Upon information and belief, the Defendant Humana Insurance Company is a corporation organized and existing under the laws of one of the States of the United States and which is licensed to do business in South Carolina and issue policies of life, health, and disability insurance.

3. The parties hereto, the subject matter hereof, and all things and matters hereinafter alleged are within the jurisdiction of this Honorable Court.

4. At all times hereinafter mention, Defendant, Humana Insurance Company, through their agents, servants and/or employees, sold Lewco Specialty Products/Carolina Technical Fabrics (hereinafter "Employer") a Group Life insurance policy with Employee Voluntary Accidental Death & Disability Benefits designated as Group Number 779283-77928302 (hereinafter "the policy"), with Kevon Belton being the insured and Dorothy Belton being the primary beneficiary.

5. Defendant Humana Insurance Company is subject to the jurisdiction of this court pursuant to S.C. Code §36-2-803(a)(6).

FACTUAL ALLEGATIONS

6. Paragraphs one (1) through five (5) above are incorporated herein the same as if repeated herein verbatim.

7. On or about December 1, 2018, Defendant Humana issued the policy to Kevon Belton with a $50,000.00 accidental death benefit (hereinafter "death benefit"). A true and accurate copy of the policy with the death benefit is attached hereto as Exhibit A.

8. Kevon Belton named his mother, Dorothy Belton, as his primary beneficiary on the policy and death benefit.

9. Prior to his death, decedent Kevon Belton paid all premiums required to keep the policy and voluntary accidental death benefit in force.

10. On December 2, 2018, Kevon Belton was operating a motor vehicle on SC-34 near Jenkinsville when he was involved in a fatal motor vehicle accident.

11. Coroner Chris Hill determined Kevon Belton's manner of death to be accidental, and the cause of death as closed head injury and multiple body trauma. A true and accurate copy of the Death Certificate of Kevon Belton is attached hereto as Exhibit B.

12. The time of the motor vehicle accident was determined to be at approximately 2:00 A.M. on December 2, 2018. The accident was not reported until approximately 7:05 A.M. that same day, and emergency responders and law enforcement officials did not arrive on scene until approximately 7:48 A.M.

13. After Kevon Belton passed away, Plaintiff Dorothy Belton submitted a claim for $50,000.00 in accidental death benefits under the subject policy.

14. Plaintiff, Dorothy Belton, is entitled to the accidental death benefits of the policy. Despite

repeated demands, the Defendant has failed and refused, and continues to fail and refuse, to pay the agreed upon policy proceeds.

FOR A FIRST CAUSE OF ACTION
(Breach of Insurance Contact)

15. Paragraphs one (1) through fourteen (14) above are incorporated herein the same as if repeated herein verbatim.

16. At all times material to the allegations contained herein, Plaintiffs' decedent Kevon Belton and Defendant, Humana Insurance Company, had a mutually binding insurance contract containing accidental death benefit among other coverages.

17. Defendant had a duty to act in good faith and pay all benefits due, including but not limited to the accidental death benefit, under the subject policy.

18. Defendant breached the insurance contract when it denied Plaintiff Dorothy Belton's claim under the terms of the policy.

19. As a direct and proximate result of Defendant's wrongful refusal to honor its insurance policy, Plaintiff has lost Fifty Thousand Dollars ($50,000.00) in accidental death benefits payable to Plaintiff under the terms of the policy, among other applicable benefits, and Plaintiff has been forced to file this lawsuit to collect benefits due.

20. As a direct and proximate result of Defendant's beach of contract and wrongful refusal to honor its insurance policy, Plaintiff Dorothy Belton has suffered actual damages of at least $50,000.00 in accidental death benefits due under the policy along with any other applicable benefits under the policy, plus interest, attorney's fees and costs of this action not exceeding $75,000.00.

FOR A SECOND CAUSE OF ACTION
(Bad Faith/Unreasonable Refusal to Pay Insurance Claim)

21. Paragraphs one (1) through twenty (20) above are incorporated herein the same as if repeated

herein verbatim.

22. At all times material to the allegations contained herein, Plaintiffs' Decedent and Defendant had a mutually binding insurance policy contract providing accidental death benefits.

23. Defendant owed Plaintiffs' Decedent a duty of good faith and fair dealing under the subject policy.

24. Defendant has wrongfully and in bad faith refused to pay Plaintiff's claims and the benefits due under the policy.

25. Following Kevon Belton's death, Defendant has asserted multiple unfounded bases to deny Plaintiff Dorothy Belton's claims for accidental death benefits reasonably due under the policy.

26. Under the facts and circumstances of this case, Defendant's refusal to honor its insurance policy is unreasonable and in bad faith and violates the implied covenant of good faith and fair dealing inherent in all contracts formed in South Carolina and further breaches its duties and responsibilities under the policy.

27. In interpreting its own insurance policy/adhesion contract and wrongfully applying the facts and circumstances of the death of Plaintiffs' decedent, Defendant placed its own financial interests ahead of the Plaintiffs.

28. Defendant's unreasonable denial of Plaintiff Dorothy Belton's claim for accidental death benefits was without basis and totally unsubstantiated by the terms of the insurance contract and facts and circumstances associated with the claim.

29. As a direct and proximate result of Defendant's wrongful and bad faith refusal to honor the terms of its insurance policy, Plaintiff Dorothy Belton has suffered actual and punitive damages for the accidental death benefit, emotional distress, attorney's fees, interest, the costs of this action, in an amount to be determined by a reasonable jury, not exceeding $75,000.00.

FOR A THIRD CAUSE OF ACTION
(Declaratory Judgment)

30. Paragraphs one (1) through twenty-nine (29) above are incorporated herein the same as if repeated herein verbatim.

31. In addition to the relief sought above, Plaintiffs believe that a justiciable controversy exists and seek a judicial declaration of the rights, status and other legal relations of the parties to this action under the terms of the subject policy issued by Defendant to Plaintiffs' Decedent, pursuant to S.C. Uniform Declaratory Judgments Act, S.C. Code § 15-53-10 *et seq*.

WHEREFORE, Plaintiffs demand a jury trial on all legal issues and claims against Defendant for actual and punitive damages, plus interest and attorney's fees, to be determined by a reasonable jury, not exceeding $75,000.00 to fully compensate the Estate of Kevon Belton. Plaintiffs likewise seek a Declaratory Judgment clarifying the obligations, benefits, and rights of the parties to this action as alleged herein.

Respectfully Submitted,

BILLY R. OSWALD LAW FIRM

s/ Bryn B. Osborne, Esq.
S.C. Bar No. 104353
1031 Center St.
West Columbia, SC 29169
(p)(803)796-7260;(f)(803)796-1055
bryn@oswaldlegal.net

West Columbia, SC
January 29, 2022

EXHIBIT A

HUMANA. Guidance when you need it most

Welcome: [redacted] Contact Us | FAQs | Glossary | Log Out

LEWCO SPECIALTY PRODUCTS

Home | Subscriber Maintenance | Reports

View Subscriber Summary | Add Subscriber | Terminate Subscriber | Modify Info/Coverage

Subscriber Summary

Print Page

To view held elections by a specific date, enter date: 12/1/2018 Reload

Subscriber name: Kevon Belton
Subscriber SSN: [redacted]

This page will print as displayed. To print specific sections(e.g. Subscriber Information's, Dependents, etc) expand the details by clicking the + icon, or you may expand all or collapse all sections

- Subscriber Information

Date of birth:	10/18/1990	Hire date:	9/9/2018
Gender:	Male	Work phone:	
Mailing Address:	1234 Hwy 21 Ridgeway, SC 29130-0000	Eligibility Group	779283- 77928302:CAROLINA TECHNICAL FABRICS
Home:			
E-mail:		Basic life class:	
Disability:	No	Subscriber status :	Full Time Employee
Communication Disabled:	No	Occupation:	
Annual Salary Amount:		Work Location:	
Hours worked weekly:	40		

+ Dependent(s)

- Open Events

Reason for Coverage Change	Event Type	Start Date	End Date	Effective Date	Status
New Hire	Individual	11/8/2018	12/9/2018	12/1/2018	Complete

- Current Coverage as on 12/1/2018

- Kevon Belton

Plan	**Network**	**Coverage level**		**Pre-Tax:**
PPO Humana, ChoiceCare and Corphealth LAHS0002	Humana, ChoiceCare and Corphealth	Employee Only	12/1/2018 - 12/2/2018	No
Dental Plan	**Coverage level**			**Pre-Tax:**
U&C TRP ADDTL ANNUAL MAX HumanaDental PPO/Traditional Preferred	Employee Only	12/1/2018 - 12/2/2018		No
Vision	**Coverage level**			**Pre-Tax:**
Waived (I'm in great health)	Waive	12/1/2018 - 12/2/2018		No
Associate Voluntary Term Life	**Coverage Amount**			
Voluntary Life with Portability and AD&D	$50,000.00	12/1/2018 -	12/2/2018	

Beneficiaries

DOROTHY BELTON

BRANDON BELTON

List of Icons

Medical | Dental | Vision

FSA/HSA | Life | Voluntary Benefits

Spouse | Dependent | Relationship

Inactive Relationship

For this subscriber:

View Coverage History

View Dependent History

Modify personal/dependent information and/or coverage

Terminate the subscriber

<<Previous

Version=1.18.5.2

Visit us at Humana.com

Small Group Employee and Individual Application and Enrollment Form - 1-50 Employees — LOUISIANA

The offering company(ies) listed below, severally or collectively, as the context may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana". To elect a primary care physician, please complete reorder LA-51340 PP.

Medical, Dental and Vision plans provided by Humana Health Benefit Plan of Louisiana, Inc. Life plans insured by Humana Insurance Company. Workplace Voluntary Benefits plans. Short Term and Long Term Disability plans insured by Kanawha Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: 12/1/18

Employer / Group name: Lewco Group # 779283 / [illegible] | Employer / Group city: Baton Rouge | State:

Qualifying Event Instructions — Date of Qualifying Event: __/__/____

- ○ New business enrollment
- ● New hire / Newly eligible
- ○ Open Enrollment event
- ○ Retiree / Reinstatement
- ○ Dependent birth or adoption
- ○ Marital status change
- ○ Loss of coverage
- ○ Other

Enrollment Information

Relationship	Last name, First name MI	Gender	Date of birth	Disabled? If yes, indicate reason below.	Social Security Number
Employee / Individual	Belton, Kevon M	○ F ● M	10/28/1990	○ Y ● N	N/A (complete in Employee/Individual Information section.)
Spouse / Domestic Partner		○ F ○ M	__/__/____	○ Y ○ N	
Child / Dependent		○ F ○ M	__/__/____	○ Y ○ N	
Child / Dependent		○ F ○ M	__/__/____	○ Y ○ N	
Child / Dependent		○ F ○ M	__/__/____	○ Y ○ N	
Other (specify):		○ F ○ M	__/__/____	○ Y ○ N	

Employee / Individual Information

Social Security Number: [redacted] | Hours worked per week: 40 | Date of full time hire: 9/19/18

Street address: PO Box 984 1234 Hwy 21 | APT / Suite / Box:

City: Ridgeway | State: SC | ZIP code: 29130 | Phone #: (803) 801-9695

Language: ● English ○ Spanish ○ Other | E-mail address: | Occupation:

Are you actively at work? ● Y ○ N If not, reason: ○ Retiree ○ COBRA Other: | Annual salary $:

Prior / Existing Coverage: IMPORTANT – DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Medical

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ● N ○ Y

Prior medical insurance carrier name | Policy # | Prior coverage type: ○ Employee / Individual only ○ Employee / Individual and spouse / Domestic partner ○ Employee / Individual and child(ren) ○ Family | Effective date __/__/____ | Term date __/__/____

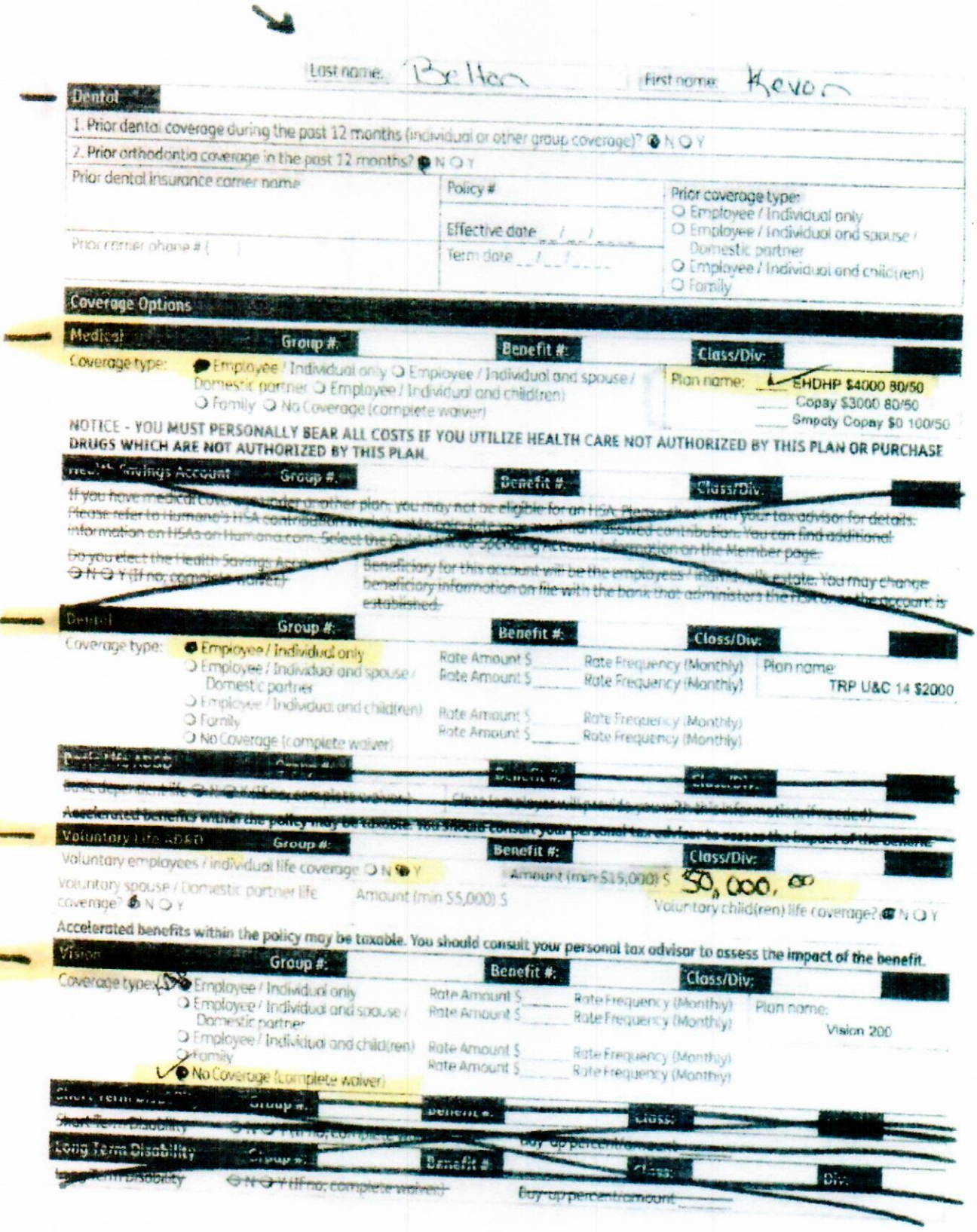
2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ● N ○ Y

Other medical insurance carrier name | Policy # | Other coverage type: ○ Employee / Individual only ○ Employee / Individual and spouse / Domestic partner ○ Employee / Individual and child(ren) ○ Family | Effective date __/__/____ | Term date __/__/____

3. Medicare

Employee / Individual coverage: ● N ○ Y | Medicare ID | Effective date __/__/____ | Term date __/__/____

Spouse / Domestic partner coverage: ● N ○ Y | Medicare ID | Effective date __/__/____ | Term date __/__/____



Last name: Bellen First name: Kevon

Dental

1. Prior dental coverage during the past 12 months (individual or other group coverage)? ● N ○ Y
2. Prior orthodontia coverage in the past 12 months? ● N ○ Y

Prior dental insurance carrier name | Policy # | Effective date | Term date | Prior coverage type: ○ Employee / Individual only ○ Employee / Individual and spouse / Domestic partner ○ Employee / Individual and child(ren) ○ Family

Coverage Options

Medical Group #: Benefit #: Class/Div:

Coverage type: ● Employee / Individual only ○ Employee / Individual and spouse / Domestic partner ○ Employee / Individual and child(ren) ○ Family ○ No Coverage (complete waiver)

Plan name: ✓ EHDHP $4000 80/50 ___ Copay $3000 80/50 ___ Simply Copay $0 100/50

NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

~~Health Savings Account~~ Group #: Benefit #: Class/Div:

~~If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details. Please refer to Humana's HSA contribution [illegible] for specific cost data, your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Accounts information on the Member page.~~

~~Do you elect the Health Savings Account? N Y (If no, complete waiver)~~

~~Beneficiary for this account will be the employee's / dependent's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.~~

Dental Group #: Benefit #: Class/Div:

Coverage type: ● Employee / Individual only ○ Employee / Individual and spouse / Domestic partner ○ Employee / Individual and child(ren) ○ Family ○ No Coverage (complete waiver)

Rate Amount $ ___ Rate Frequency (Monthly) Rate Amount $ ___ Rate Frequency (Monthly) Rate Amount $ ___ Rate Frequency (Monthly) Rate Amount $ ___ Rate Frequency (Monthly)

Plan name: TRP U&C 14 $2000

~~Basic dependent life N Y (If no, complete waiver) Class (employee eligible to provide this information if needed)~~

~~Accelerated benefits within the policy may be taxable. You should consult your personal tax advisor to assess the impact of the benefit.~~

Voluntary Life (AD&D) Group #: Benefit #: Class/Div:

Voluntary employee / individual life coverage ○ N ● Y Amount (min $15,000) $ 50,000.00

Voluntary spouse / Domestic partner life coverage? ● N ○ Y Amount (min $5,000) $

Voluntary child(ren) life coverage? ● N ○ Y

Accelerated benefits within the policy may be taxable. You should consult your personal tax advisor to assess the impact of the benefit.

Vision Group #: Benefit #: Class/Div:

Coverage type: ● Employee / Individual only ○ Employee / Individual and spouse / Domestic partner ○ Employee / Individual and child(ren) ○ Family ✓ ● No Coverage (complete waiver)

Rate Amount $ ___ Rate Frequency (Monthly) Rate Amount $ ___ Rate Frequency (Monthly) Rate Amount $ ___ Rate Frequency (Monthly) Rate Amount $ ___ Rate Frequency (Monthly)

Plan name: Vision 200

~~Short Term Disability Group #: Benefit #: Class:~~

~~Buy-up percent/amount~~

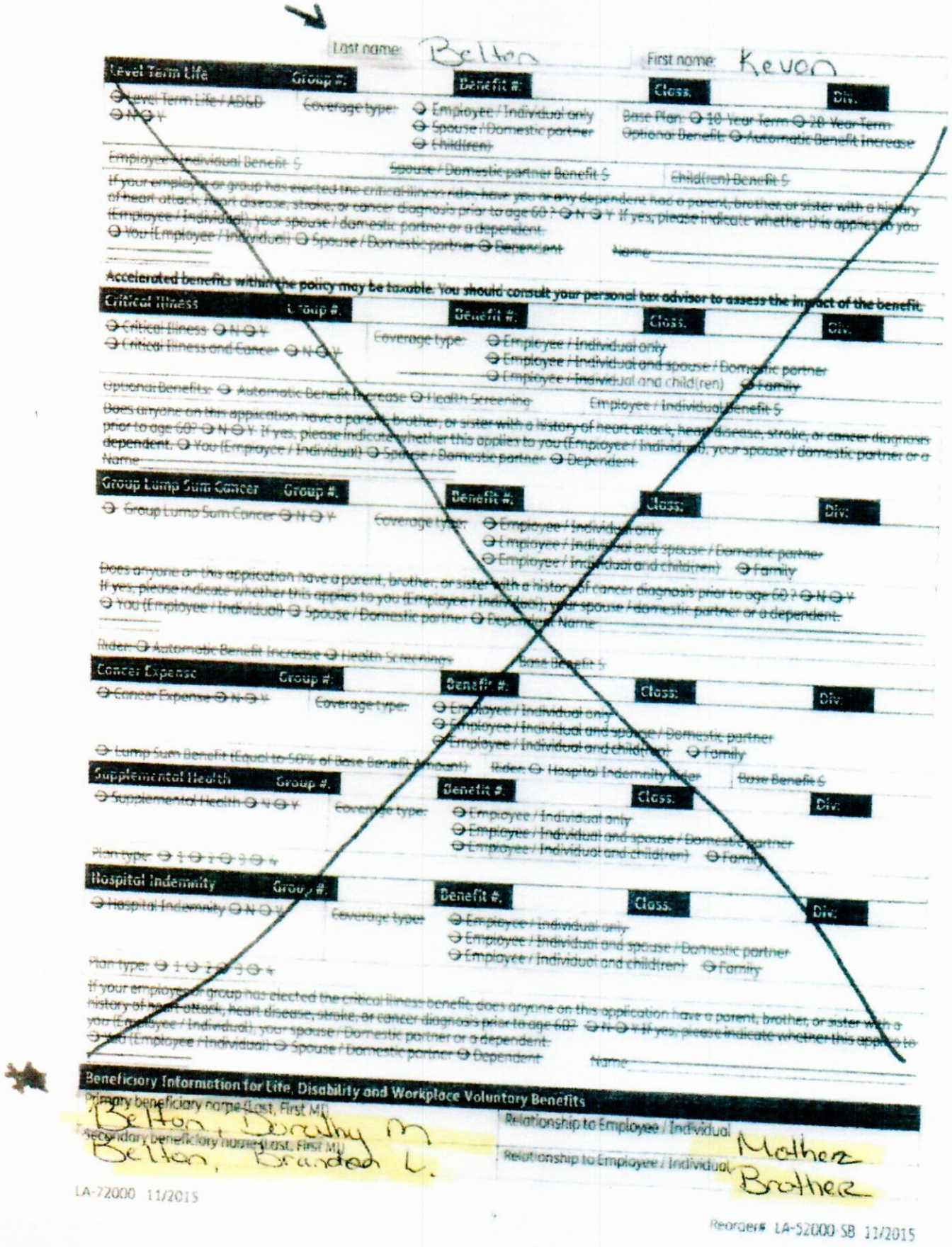
~~Long Term Disability Group #: Benefit #: Class: Div:~~

~~Long Term Disability ○ N ○ Y (If no, complete waiver)~~

~~Buy-up percent/amount~~

LA 72000 11/2015

Reorder# LA 52000 SB 11/2015



Last name: Belton First name: Kevon

Level Term Life Group #: Benefit #: Class: Div:

~~Level Term Life / ADLD~~ ~~Y N~~ Coverage type: ~~Employee / Individual only~~ ~~Spouse / Domestic partner~~ ~~Child(ren)~~ Base Plan: ~~10 Year Term~~ ~~20 Year Term~~ Optional Benefit: ~~Automatic Benefit Increase~~

~~Employee / Individual Benefit $~~ ~~Spouse / Domestic partner Benefit $~~ ~~Child(ren) Benefit $~~

~~If your employer group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? N Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse / domestic partner or a dependent.~~

~~You (Employee / Individual) Spouse / Domestic partner Dependent~~ Name:

Accelerated benefits within the policy may be taxable. You should consult your personal tax advisor to assess the impact of the benefit.

Critical Illness Group #: Benefit #: Class: Div:

~~Critical Illness N Y~~ ~~Critical Illness and Cancer N Y~~ Coverage type: ~~Employee / Individual only~~ ~~Employee / Individual and spouse / Domestic partner~~ ~~Employee / Individual and child(ren)~~ ~~Family~~

Optional Benefits: ~~Automatic Benefit Increase~~ ~~Health Screening~~ ~~Employee / Individual Benefit $~~

~~Does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? N Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse / domestic partner or a dependent. You (Employee / Individual) Spouse / Domestic partner Dependent~~ Name:

Group Lump Sum Cancer Group #: Benefit #: Class: Div:

~~Group Lump Sum Cancer N Y~~ Coverage type: ~~Employee / Individual only~~ ~~Employee / Individual and spouse / Domestic partner~~ ~~Employee / Individual and child(ren)~~ ~~Family~~

~~Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60? N Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse / domestic partner or a dependent. You (Employee / Individual) Spouse / Domestic partner Dependent~~ Name:

~~Rider: Automatic Benefit Increase Health Screenings~~ ~~Base Benefit $~~

Cancer Expense Group #: Benefit #: Class: Div:

~~Cancer Expense N Y~~ Coverage type: ~~Employee / Individual only~~ ~~Employee / Individual and spouse / Domestic partner~~ ~~Employee / Individual and child(ren)~~ ~~Family~~

~~Lump Sum Benefit (Equal to 50% of Base Benefit Amount)~~ ~~Rider: Hospital Indemnity Rider~~ ~~Base Benefit $~~

Supplemental Health Group #: Benefit #: Class: Div:

~~Supplemental Health N Y~~ Coverage type: ~~Employee / Individual only~~ ~~Employee / Individual and spouse / Domestic partner~~ ~~Employee / Individual and child(ren)~~ ~~Family~~

~~Plan type: 1 2 3 4~~

Hospital Indemnity Group #: Benefit #: Class: Div:

~~Hospital Indemnity N Y~~ Coverage type: ~~Employee / Individual only~~ ~~Employee / Individual and spouse / Domestic partner~~ ~~Employee / Individual and child(ren)~~ ~~Family~~

~~Plan type: 1 2 3 4~~

~~If your employer group has elected the critical illness benefit, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? N Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse / domestic partner or a dependent. You (Employee / Individual) Spouse / Domestic partner Dependent~~ Name:

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary name (Last, First MI): Belton, Dorothy M Relationship to Employee / Individual: Mother

Secondary beneficiary name (Last, First MI): Belton, Brandon L. Relationship to Employee / Individual: Brother

LA-72000 11/2015

Reorder# LA-52000 SB 11/2015

Last name: Belton First name: Kevon

~~If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder LA-51340-MB), if necessary.~~

~~Question #~~ ~~Person treated (Last name, First name)~~

~~Condition~~

~~Treatments received~~

~~Medications prescribed~~

~~Current or future treatments or medications~~

~~Date diagnosed~~

~~Date last seen by a doctor~~

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply):

Medical for:	○ Myself	○ My spouse / Domestic partner	○ My dependent child(ren)
Dental for:	○ Myself	○ My spouse / Domestic partner	○ My dependent child(ren)
~~[illegible]~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
Vision for:	○ Myself	○ My spouse / Domestic partner	○ My dependent child(ren)
~~Short-Term Disability for:~~	~~○ Myself~~		
~~Long-Term Disability for:~~	~~○ Myself~~		
~~Health Savings Account for:~~	~~○ Myself~~		
~~Whole Coverage for Workplace Voluntary Benefits:~~			
~~Whole Life for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Level Term Life for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Critical Illness for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Group Lump Sum Payment for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Cancer Expense for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Supplemental Health for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Accident for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Hospital Indemnity for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Disability Income Plus for:~~	~~○ Myself~~	~~○ My spouse / Domestic partner~~	~~○ My dependent child(ren)~~
~~Disability Income Advantage for:~~	~~○ Myself~~		

I decline to apply for group coverage because of:

- ○ Spousal / Domestic partner coverage
- ○ Medicare supplement
- ○ Individual coverage
- ○ Coverage under another carrier's plan provided by my employer / group
- ○ Other

Agreement

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Small Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Small Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Small Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- Based on the coverage I have elected, I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse / Domestic partner) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends.
- If I am declining coverage for myself or my dependents (including my spouse / Domestic partner) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Small Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.

Last name: Belton First name: Kevon

- If I am applying for coverage for my dependents (including my spouse / Domestic partner) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Small Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Small Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce an individual's or group's coverage or may increase past premium.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Small Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information or misstatements in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:

- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

This authorization shall be valid for two years from the date shown below or until the date your coverage terminates, whichever comes first and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

Humana will not require an applicant for coverage or an individual or family member to be the subject of a genetic test or to be subjected to questions relating to genetic information.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

The Small Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Does the applicant have any existing life or disability insurance policy(s) and/or annuity(s)? ○ N ○ Y

Employee / Individual or legal representative signature: Kevon Belton Date: 12-26-18

Name and relationship of legal representative:

Spouse / Domestic partner signature: Date:
(Only if selecting Life coverage over the guarantee issue amount.)

EXHIBIT B

STATE OF SOUTH CAROLINA

CERTIFICATION OF VITAL RECORD

DEATH CERTIFICATION

STATE FILE NUMBER : 139-18-045696

DECEDENT'S NAME: *KEVON MARTELL BELTON*
SEX: MALE
AKA's: NA
SOCIAL SECURITY NUMBER: 251-87-7640
ARMED FORCES: NO
DATE OF BIRTH: OCTOBER 18, 1990
AGE: 28 YEARS
TYPE OF PLACE OF DEATH: OTHER (SPECIFY)
COUNTY OF DEATH: FAIRFIELD
NAME AND ADDRESS OF PLACE OF DEATH: 1 HWY 34 HIGHWAY WEST, BLAIR, SC 29015
PLACE OF DISPOSITION: BIBLE LIGHT 2 - GREENBRIER CEMETERY
DISPOSITION LOCATION: WINNSBORO, SOUTH CAROLINA
METHOD OF DISPOSITION: BURIAL
DECEDENT'S RESIDENCE: 1234 US HWY 21 HIGHWAY SOUTH, RIDGEWAY, FAIRFIELD COUNTY, SC, 29130
PLACE OF BIRTH: SOUTH CAROLINA
MARITAL STATUS: NEVER MARRIED
SURVIVING SPOUSE'S NAME: NA
FATHER'S NAME: BARRY BELTON
MOTHER'S NAME PRIOR TO FIRST MARRIAGE: DOROTHY BOYD
INFORMANT'S NAME: BARRY BELTON
RELATIONSHIP: FAMILY MEMBER
MAILING ADDRESS: 1234 US HWY 21 S, RIDGEWAY, SC, 29130
FUNERAL HOME: NELSON'S FUNERAL HOME, LLC, 270 N DOGWOOD AVE, RIDGEWAY, SC, 29130
FUNERAL DIRECTOR: EDDIE J NELSON
LICENSE NUMBER: 1592
EMBALMER'S NAME: EDDIE J NELSON
LICENSE NUMBER: 1592
ACTUAL OR PRESUMED DATE OF DEATH : DECEMBER 02, 2018
MANNER OF DEATH : ACCIDENT
ACTUAL OR PRESUMED TIME OF DEATH: 0200
CAUSE OF DEATH - PART I
CLOSED HEAD INJURY
MUTIPLE BODY TRAUMA

OTHER SIGNIFICANT CONDITIONS - PART II:
NONE

CORONER CONTACTED? YES **AUTOPSY PERFORMED?** NO **AUTOPSY AVAILABLE?** NA
DATE OF INJURY: DECEMBER 02, 2018 **TIME OF INJURY:** 0200 **INJURY AT WORK?** NO
PLACE OF INJURY: HIGHWAY 34 WEST AND ZION HOPEWELL CHURCH ROAD
LOCATION OF INJURY: 34 WEST 34 HIGHWAY WEST, BLAIR, FAIRFIELD COUNTY, SC, 29015
HOW THE INJURY OCCURRED?
MOTOR VEHICLE COLLISON

CERTIFIER NAME AND TITLE: CORONER CHRIS HILL **LICENSE NUMBER:** NA
CERTIFIER'S ADDRESS: 315 S. CONGRESS STREET, WINNSBORO, SC, 29180
DATE FILED: DECEMBER 04, 2018
DATE OF ISSUANCE: DECEMBER 04, 2018
SPECIAL INSTRUCTIONS :
NA

SC07359348

This is a true certification of the facts on file in the Division of Vital Records, SC Department of Health and Environmental Control.

David E. Wilson, Jr.
Acting Director

Angelia P. Saleeby
Assistant State Registrar

This is watermarked paper. Do not accept without noting watermark. Hold to light to verify watermark.

Revision Date: 04/09/2018

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

Plaintiff's Ex. B